Burnett (S. G.)

# The Diagnosis of Incipient Melancholia.

*An Abstract of a Lecture delivered before the Class of the Kansas City Medical College.*

BY

S. GROVER BURNETT, A. M., M. D.,

KANSAS CITY, MO.,

Lecturer on Clinical Diseases of the Nervous System in the Kansas City Medical College.

REPORTED BY COLFAX SANDERSON.

REPRINTED FROM

The New York Medical Journal

*for May 2, 1891.*

*Reprinted from the New York Medical Journal*
*for May 2, 1891.*

# THE DIAGNOSIS OF INCIPIENT MELANCHOLIA.

AN ABSTRACT OF A LECTURE DELIVERED BEFORE
THE CLASS OF THE KANSAS CITY MEDICAL COLLEGE

By S. GROVER BURNETT, A. M., M. D.,
KANSAS CITY, MO.,
LECTURER ON CLINICAL DISEASES OF THE NERVOUS SYSTEM
IN THE KANSAS CITY MEDICAL COLLEGE.

Reported by COLFAX SANDERSON.

Gentlemen: Our remarks during this meeting will be brought to bear principally upon illustrations which will tend to give us a comprehension of a group of symptoms leading us to a reliable diagnosis of that affection known as melancholia in its incipiency. The indications to be mentioned are not to be found in your text-books, but they are purely the results of clinical investigation. Before advancing with the subject, as students, we should understand the significance of the term melancholia. Meynert considers it as a symptomatic disease arising from trophic disturbances of the anterior lobes of the brain, that part looked upon as the seat of intelligence, and the changes taking place here are the reverse of those found in subjects suffering from mania.

In mania we have an exaggerated activity of both mind

and body; the cortical cell functions are increased in activity till there is a liberation of inco-ordinated brain force, resulting in inco-ordination of ideas, accompanied by bodily actions varying in degree from slight perversion to extreme violence.

In melancholia there is a dejected and saddened appearance, with decreased activity of mind and body, slow and defective mental reflexes, and a delirium of self-reproach and persecution.

Meynert believes the symptoms found in melancholia are the result of an anæmic condition of the cerebral cortex. Clinically, we know that an abnormally anæmic condition of any organ means *starvation*, followed by a decrease and change in function, and, if continued long enough, the condition must become degenerative in character.

In mania there is an excessive activity of cortical functions, due to an abnormally hyperæmic condition. Clinically, we know that such a condition means increased stimulation and activity, resulting in decreased nutrition; and that, if continued for a sufficient length of time, it will give us a change in tissue structure pathologically known as of the proliferative type.

One of the latest classifications of melancholia is that given by Mendel where he divides it into three forms; but I see no superiority in it over the classification used by my friend and teacher, Dr. Landon Carter Gray.

In this, melancholia is divided into simple melancholia, melancholia agitata, melancholia attonita, and melancholia with stupor; clinically, this is simple and accurate, and those familiar with the disease, on entering the ward for such cases, will readily pick out the cases belonging to each classification. The ease with which we shall be able to make our diagnosis will depend upon our knowledge and the duration of the disease. The necessity of an early diag-

nosis in melancholia attonita and melancholia with stupor, from a standpoint of safety, is not so great as in the other two forms, and, in my experience, is not in many instances so difficult.

Simple melancholia and melancholia agitata are the forms that so frequently escape an accurate diagnosis in the early stage of the disease, and it is in these forms that we are to expect the safety of the patient, or those about him, to become endangered.

Too frequently melancholia is allowed to go on in its incipiency unrecognized as to the true nature of the affection present, but instead is diagnosticated as "neurasthenia," "nervous exhaustion," etc., a condition entirely foreign to the one that should not be overlooked, and with such a diagnosis the patient is treated in a like indefinite manner until the realization of the true nature of the disease is forced upon us through the medium of some tragic affair, either homicidal, suicidal, or both. This peculiar tendency of the disease renders its early recognition of the utmost importance.

*Simple Melancholia.*—Usually in this form of the disease we find it unattended by delusions, hallucinations, and illusions which are common in the other classifications. It is true there may be a tendency to their development, but they are rarely definite enough to be of diagnostic value. In the early part of this form of the affection the intellectual faculties are seemingly unimpaired, and, unless the examiner is an expert, it will be with no little difficulty that he will be able to recognize any pronounced defect in the memory and ability to reason; hence the importance of diagnostic symptoms at this period. While the indications to be brought out are not confined to the incipiency, it is at this time that their recognition will be of the greatest aid to us in simple melancholia and melancholia agitata. As to

their significance in melancholia attonita and melancholia with stupor we shall speak later on.

The case I shall now present to you is of interest, and will illustrate to you the features to which I wish to call attention.

Mr. F. was born in Germany, is thirty-five years of age, a tinsmith by trade, and has been in this country a number of years. His mother died of phthisis pulmonalis; the father he knows nothing of, and he has no brothers or sisters. As you observe him, the most remarkable feature is his sad and depressed countenance. Here I would remark that his case has been looked upon as one of hyponchondria, and treated as such on account of this sadness and his intermingled fears. Now, there is a marked difference between simple sadness and melancholia. In the former there is a cause comprehensible to the individual, and he will seek to remove it. In the latter there is no apparent cause; there is some implication of the higher faculties, and the patient usually is indifferent to his condition, surroundings, and future progress.

On questioning this man, I find a remarkable exactness in his answers and he reasons fairly well, though there is dullness of his perceptions and mental reflexes, showing a degree of impairment of the intellectual faculties. He now has depressed fears, and imagines, when questioned closely, that he has committed some great sin, and, in order to be forgiven, in his judgment, it was necessary for him to desert his life-long Protestant Church and become a Catholic that he might go to confession and be pardoned; this he has done.

By further investigation I find insomnia appearing as an early symptom. He tells me it was persistent and unremitting, and when he did sleep it was only to be tortured by horrifying and frightful dreams, and that the

period of repose was only of short duration. At an early date he suffered from a pain in the back of the neck and head radiating over a region corresponding about to the attachment of the *ligamentum nuchæ*, and, owing to the nature and permanent situation of this symptom, I have given it the name of *nuchalalgia*. Ingrafted on these two symptoms given we have a melancholy tendency at first, which later on will become profound in true cases of melancholia. You will observe now we have three well-defined symptoms, and to impress their value upon you I would suggest that you call them "three of a kind," for clinically I have found their recognition in incipient melancholia equal to "taking the trick" every time. Then remember them—namely, insomnia, nuchalalgia, and melancholia.

While my attention was first called to these points as being significant in the diagnosis of incipient melancholia as far back as the latter part of 1886, I have never made any use of them outside of my hospital and private practice until I now give them to you. Even now I do not think I am justified in giving them to you as being especially developed by myself, for my attention has been called to an article by Dr. Gray in the *Journal of Mental and Nervous Disease* for January, 1890, in which he has ably dealt with the same indications. The fact that the observations were made by us unknown to each other and that mine began in 1886 and Dr. Gray's, I think, in 1887, is worthy of consideration in substantiating the facts as being diagnostic features.

The term nuchalalgia, which I have given to the pain, the location of which has just been given and which is rather of a dull ache in character, I concluded was a significant though perhaps a clumsy term, as it not only describes the nature of the symptom, but also defines quite

accurately its location. In some instances, it is true, I have found the pain radiating over a more extensive area, but, from a clinical deduction taken from a record of thirty cases in which the symptom was present, it occurs to me that the characteristic pain or ache is about limited to the area corresponding to the attachments of the *ligamentum nuchæ*. Dr. Gray calls this symptom "post-cervical ache." This is certainly significant, but as the ache, in my observation, was so rarely limited to the post-cervical region and so generally extended to the back of the head, the term seemed too limited for the indications present. However, it is not so much the name of the symptom to which I desire calling your attention as it is the recognition of this symptom, for, taking it in connection with other premonitory indications, such as a melancholic tendency, insomnia, and decrease in mental responses and perceptions, accompanied by retarded speech and actions, all of which are a departure from the normal or healthy state of the mind, I feel justified in saying to you you will find the recognition of nuchalalgia a potent factor in leading to the early diagnosis of the simple form of melancholia.

Dr. Gray says he has found "the characteristics of this peculiar melancholia, the causelessness, the indifference, the slow mental reflexes, with the occasional history of terrifying delusions and hallucinations, remarkably constant, and they are so significant that I have again and again based upon them a diagnosis which further examination has verified." I find this a clear expression of facts substantiated by clinical observation, and in this case here before you, by their presence, I have been able to obtain the fact that this is now the gentleman's second attack. When I asked him how long before this he had suffered from pain in the back of his head and neck, was unable to sleep, was depressed in spirits, did not care to live, and had

fears of distrust, etc., he looked at me suspiciously and wanted to know how I had been informed of these facts, as he had never seen me before. After I assured him I was positive in the matter, he told me he had suffered from a similar attack some years ago, lasting about six months. This is why I was so anxious to show you this individual patient, as his presence is of more value to you than a large tabulation of cases.

Why we have spent so much time in speaking of simple melancholia is because of the frequency with which we find it overlooked in the incipient stage.

In melancholia agitata I have found our trio of symptoms present with remarkable exactness; but this form of the disease is not so difficult to diagnosticate, as a rule; the agitation of itself, in the chain of other symptoms (except where it develops late), is quite indicative. An interesting case illustrating this is the following:

Miss ——, aged twenty-three; admitted, I think, in April, 1887. She suffered from nuchalalgia, insomnia, depression, etc. I asked the brother, an intelligent young man, regarding a former attack, which, if I remember correctly, had occurred about three years previously, and, fearing such a recurrence, he desired early precautions. She remained under observation, and by the end of the second week hers became one of the severest cases of melancholia agitata that it has been my lot to observe where a good recovery followed without any apparent stigma remaining.

After she had been in the hospital two weeks her condition was such as to require the attention of two nurses to keep her clothing on her. She had hallucinations, delusions, and illusions of the most terrifying nature. Her mental reflexes were extremely morbid, and her indifference to herself and surroundings was such as to cause her to refuse food, resulting in the necessity of resorting to artificial

feeding by means of the œsophageal tube for a period of about three or four weeks. She became frightfully emaciated before improvement began. During this time her insomnia was profound, and she never slept except when under the influence of hypnotics. Whenever there was a subsidence of her mental agitation sufficient to allow her to converse, she complained constantly of nuchalalgia or, according to Dr. Gray, the post-cervical ache. The photograph I present to you is an excellent representation of her as she appeared after convalescence. You will observe the degree of intelligence indicated, the firmness of expression (somewhat mature for a girl of twenty-three), and the complete absence of a melancholy countenance. So perfect a recovery from such a pronounced attack of melancholia without leaving the melancholy tracings is, in my experience, not common.

In six months from the onset of the attack she had recovered herself well, with the exception of the insomnia and nuchalalgia, both of which seemed to persist in a mild form. This is a feature I would have you remember, as I have found there is a tendency for it to last a long time, especially in simple and agitated melancholia. Notwithstanding their mild persistence, through solicitation, the patient was allowed to go home, but returned at the end of ten days with an increase in the severity of all her symptoms. She now remained about six weeks longer, when she was discharged apparently well, and, so far as I can learn, she has remained so to the present time.

Where there is this tendency to continued nuchalalgia in the convalescent stage (and it is common), I find it going hand in hand with insomnia—that is, there is apt to be a renewed loss of sleep, even though sleep has been apparently restored. Now, the question arises whether we are to hold the former responsible, in this instance, for the

secondary development of the latter, as well as some mental symptoms—such as confusion and melancholia—which are indicative of a recurrence of the old trouble. If so, which seems rational, it is an important suggestion as to the treatment to be inaugurated.

Just as to the relation of this trio of symptoms to the remaining two classes—namely, melancholia attonita and melancholia with stupor—I am not sufficiently positive to state. That I have not been able to recognize them in these stages, as in the two first forms, I am free to confess, though in a few instances in the atonic form I have been able to recognize them at periods, but not with sufficient accuracy to be of diagnostic importance; the nuchalalgia was not constant, or, if it was constant, the condition of the patient was such as to render it obscure much of the time, and when it was present it did not maintain its usual severity and distressing characteristics, so common in the other forms. The stuporous condition of itself would seem sufficient to either render the patient insensible to the pain, or make it unrecognizable to the observer. Another feature that would suggest the absence of nuchalalgia in these two classes is the fact that the insomnia is not so persistent during the convalescent period. If you remember, I spoke of insomnia being almost invariably present during that period of simple and agitated melancholia. Then, while the weight of observation is against the presence of our symptoms here as being diagnostic, I shall withhold making any positive statement yet awhile, for I do not wish to place any stumbling-blocks in your way as students.

Insomnia is present in some degree in all the forms of melancholia, being more marked in simple melancholia and melancholia agitata than it is in melancholia attonita and melancholia with stupor; this would suggest

again that the nuchalalgia was playing its part here in the rôle of production. I do not mean to assert that it is necessary at all times to have the nuchalalgia present in order that there may be insomnia, for I believe the delusions are often sufficient to keep patients awake. I have often, while making my rounds of the wards, at all hours of the night, had occasion to observe this condition, and it has not been uncommon to find these patients wide awake with no indications of having been asleep.

Why are diagnostic symptoms important in incipient melancholia?

As I have said, it is in the early periods of the disease that it is so frequently improperly diagnosticated, and it is the inherent tendency of these very cases to become homicidal and suicidal. Such instances as these are the very ones that fill our daily newspapers with tragic sensationalism, and leave the general public wrapped in the mystic thought of some dastardly deed, which has simply been the outgrowth of a depressed and melancholy mind. Such an occurrence as this—which, I am sorry to say, is more common than you would imagine—is sufficient to point out to us the importance and usefulness of any symptom or group of symptoms that will lead to the recognition of a mental derangement which, sooner or later, will bring crime to the eyes of the public; humility, distress, and perhaps death in private life.

This propensity to take life may come upon them suddenly, or be gradual in its development. I recall the case of a large, heavy man who was determined to take his life. In conversation he would reason quite well on many things, but when alone he would be seized with a fit of depression and a desire to kill himself. Notwithstanding he was closely watched, he evaded his attendant and threw himself head first down a stone stairway. He reasoned that the weight

of his body, falling from a height on his head, would produce death. Unfortunately for him, he struck his head a glancing blow, as he jumped hurriedly and at an angle, rather than perpendicularly. He suffered from concussion of the brain, but survived his injury. All cutting and sharp-pointed instruments had to be taken from him. Shortly after being able to leave his bed he again evaded the nurse, and this time he jumped from the railing of a high piazza, head first, and, as he had reasoned, his weight was sufficient to drive the cervical vertebræ into the base of the skull, producing instant death.

It is not uncommon to see melancholiacs whose real condition has not as yet been recognized awaiting some suggestion through which they may be able to carry out their morbid tendencies. A case of this kind was that of a gentleman who was noticed by his associates to be somewhat depressed. They thought to chide him a little and "drive away his blues," when he remarked he wished he was dead. One of the company carelessly remarked: "Go throw yourself over the stair railing." He deliberately carried out the suggestion before any of them had time to interfere. He fell through three floors on to a tile floor, killing himself, of course.

Suicidal and homicidal acts are frequent results of disappointed love affairs, and in these instances the real melancholia, which is undoubtedly secondary to the extreme disappointment and is responsible for the act, is often never recognized till it is too late.

Such occurrences are so common that it is useless to take up more time in illustrating this feature of melancholia, which is deserving of being considered an early diagnostic symptom, and is important both to the practitioner and to the neurologist. From a therapeutic and diagnostic standpoint it can not be otherwise than recognized as of great

efficacy. To arrive at a proper diagnosis, based upon various forms of depression, is not always an easy matter, for we find depression presenting itself in a variety of forms, each of which is dissimilar in its origin. Mental depression may be the initiative symptom of any form of mental disease, and, again, it may exist independent of any mental affection whatever. Gastric disorders often give rise to marked depression, also hysteria, hypochondria, and conditions of sadness. A differential diagnosis here is important, but not always easy to make. If the depression exists in connection with nuchalalgia and insomnia, the rest is easy.

*Therapy*, of course, should be based on the diagnosis made; hence, with a history which is in keeping with the presence of insomnia, the ache, and depression, we should feel quite positive as to what we have to deal with, and should institute precautions of safety and therapeutic measures at once. By this early interference I believe much mental aggravation and distress may be saved; but, in order to do this, it is essential for the physician to be conversant with the case and to have *entire* control, so that his instructions will be carried out in full.

As students about to enter into your new field of duties, I trust you may give this matter due consideration, for my clinical experience has taught me the value of these symptoms given you, and, since I have learned that they are ardently advocated as *clinical facts* by one so able as Dr. Gray, I am proud to have the privilege of presenting them to you for the first time.